MODEL APPLICATION TEMPLATE FOR
STATE CHILD HEALTH PLAN UNDER TITLE XXI
OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

MODEL APPLICATION TEMPLATE FOR
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b))

State/Territory: Wisconsin
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b))

_____
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

Name: Angela Dombrowicki Position/Title: Bureau Director

Name: Greg DiMiceli Position/Title: Analyst

Name: Position/Title:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) (42 CFR 457.70):

1.1.1. ☐ Obtaining coverage that meets the requirements for a separate child health program (Section 2103); OR

1.1.2. ☒ Providing expanded benefits under the State's Medicaid plan (Title XIX); OR

1.1.3. ☐ A combination of both of the above.

1.2 ☒ Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

1.3 ☒ Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment (42 CFR 457.65):

Effective date: July 1, 1999

Implementation date: July 1, 1999

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (42 CFR 457.80(a))

The Wisconsin Department of Health and Family Services annually conducts a Family Health Survey. The Wisconsin Family Health Survey was initiated in 1989 to collect information about the health status, health problems, health insurance coverage, and use of health care services among Wisconsin residents. A random sample of households is telephoned by trained interviewers. The adult in each household who knows the most about the health of all household members is selected to answer all survey questions during the telephone interview. This person answers survey questions for him/herself as well as for all other household members. In 2002, 70 percent of the respondents were women.

In 2002 the Family Health Survey conducted interviews with 3,089 households comprised of 7,995 individuals. This sample represents the 5,266,000 Wisconsin residents living in households during 2002. There were an estimated 1,416,000 children age 18 and younger in Wisconsin households. The survey was conducted from May through December 2002.

<u>Coverage Over the Past Year</u>

- The majority of Wisconsin household residents were covered by health insurance for an entire year, based on findings of the 2002 Wisconsin Family Health Survey. Eighty-nine percent of Wisconsin residents had insurance for all 12 months prior to the survey interview, 7 percent had insurance for some of the past 12 months, and 4 percent had no insurance coverage at all during the past 12 months.
- An estimated 4.7 million state residents were insured for all 12 months prior to the survey; 352,000 were insured part of the past year and uninsured part of the year; 203,000 had no insurance coverage during the past year.
- Among children under age 19, 91 percent were insured for all 12 months prior to the survey, 6 percent (90,000) were insured part of the year and uninsured part of the year, and 3 percent (36,000) had no insurance coverage during the past year.
- There were 424,000 low-income children under age 19 (living in households with annual incomes below 200 percent of the federal poverty level). They were more likely to be uninsured for part or all of the past year (14%) than were higher-income children (7%).
- Among working-age adults, 18 to 64, those working full time for an employer were

without health insurance for the entire past year at a lower rate (4%) than were the full-time self-employed (7%).

The proportion without health insurance coverage for the entire year was higher among Hispanic residents (10%) than among non-Hispanic white people (3%) or people of two or more races (2%). It was also higher among poor residents (11%) than among near-poor (6%) and non-poor (2%) residents.

Current Coverage (Point-in-time)

- At any point in time during 2002, an estimated 4.9 million Wisconsin household residents (93%) were covered by health insurance, while about 336,000 residents (6%) were uninsured.
- Among children under age 19, an estimated 54,000 (4%) were uninsured. Seven percent (30,000) of low-income children were uninsured, compared to 2 percent (24,000) of higher income children.
- Children, ages 0-17, living with an employed adult were more likely to have insurance coverage than children in households without any employed adults (96% vs. 85%).
- Younger adults, ages 18 to 44, were more likely to be uninsured than other age groups (10% uninsured in 2002). Conversely, adults age 65 and older were most likely to have insurance coverage at any point in time (99% insured).
- Both black adults and Hispanic adults were more likely to be uninsured than were white adults.
- Among children, black children were about as likely to be insured as white children (98% and 96%, respectively). Hispanic children were less likely to be insured (91%).

Type of Health Insurance Coverage

- Employer-sponsored insurance is the most prevalent type of coverage for people under age 65; it covers three-quarters of all people in this age group.
- Among adults age 65 and older, 93 percent have Medicare coverage and most have supplemental coverage as well. Only 8 percent of this age group has Medicare with no supplement.

Comparing children in the 1995 Family Health Survey to the 2002 survey, the number of uninsured children ages 0-18 living in households with incomes below 200 percent of the federal poverty level decreased from 77,000 to 30,000. Among children in households above 200 percent of poverty, the number uninsured decreased less dramatically, from 30,000 to 24,000.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2) (42CFR 457.80(b))

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children

who are eligible to participate in public health insurance programs (i.e., Medicaid and state-only child health insurance):

Wisconsin Medicaid is the state's major public health program for children. Medicaid is a federal/state health care program for low-income families, elderly and disabled individuals. It serves many of the poorest and most vulnerable citizens of Wisconsin.

In the 1997-1999 biennium, Medicaid is the largest program supporting non-governmental entities supported by Wisconsin general purpose revenue (GPR). The Medicaid GPR budget for the biennium is approximately $1.85 billion. This amount represents roughly 40 percent of total program costs; federal funds support the remaining 60 percent of costs.

Wisconsin Medicaid offers one of the most comprehensive benefit packages of any state Medicaid program and covers most individuals eligible under federal regulations. At the same time, Wisconsin Medicaid is a very cost-effective program.

The Wisconsin Department of Health and Family Services is the largest single provider of direct as well as support services for uninsured and Medicaid-enrolled children and adolescents. Direct services for this population include: preventive child health services (well-child check-ups), prenatal services, Women Infants and Children Supplemental Nutrition (WIC) program services, preventive health education, immunizations, and family planning program services. Support services include case management services, the provision of information and referral via toll-free telephone lines, and laboratory services. These services are funded through federal Title V Maternal and Child Health Block Grant funds, federal Title X Family Planning program funds, federal WIC Program funds, Medicaid program reimbursements, federal immunization funds, state legislative appropriations, some local government appropriations, and a small amount of patient fee revenue.

The State of Wisconsin has increased the percentage of low-income families with health insurance through a variety of initiatives:

- Healthy Start Expansion. Wisconsin has increased the Medicaid income limit for low-income pregnant women and children under age six over the years since 1988, when the program began, from 120 percent of the federal poverty level (FPL) to the current level of 185 percent of the FPL. In 1989, the asset test was eliminated for Healthy Start.

- W-2 Health Plan. Provisions of 1995 Wisconsin Act 289 authorized the W-2 welfare reform program. A part of this program was the W-2 Health Plan, which was designed to provide health care to low-income families, dependent children, and working parents who could not afford health insurance. The program was designed as a bridge to self sufficiency, providing affordable health insurance to low-income, working families and assuring a transition to

private health insurance. The program applied to persons in W-2 work programs and other low-income families. The federal waiver required for Wisconsin to implement this health care component was not granted.

- BadgerCare. Provisions of 1997 Wisconsin Act 27, enacted on October 11, 1997, authorized statutory language and state matching funds from state GPR (tax revenues) to create the BadgerCare program. Under the legislation, BadgerCare will begin on July 1, 1998.

The following chart illustrates the significant differences between the proposed W-2 Health Plan and the newly proposed BadgerCare.

W-2 Health Plan	**BadgerCare Plan**
♦ Eliminated coverage for all AFDC-related and Healthy-Start Medicaid program groups	♦ Retains coverage of all currently eligible populations; creates eligibility for additional new populations
♦ Eliminated population included: All individuals/families with incomes over 165 percent of the FPL, including pregnant women and children under age six	♦ Eligible population includes: All children and families with incomes up to 185 percent of the FPL. Once enrolled, families may remain in the program until their income reaches 200 percent of the FPL
♦ Individuals became ineligible if their employers offer insurance and the employer pays at least 50 percent of the cost of that insurance	♦ Individuals become ineligible if their employers offer family insurance and the employer pays 80 percent of the cost of that insurance or, as required under federal law, the family member has HIPAA coverage
♦ Assessed a premium share on all participating families, regardless of income level	♦ Premium shares are only assessed on families whose income is at or above 150 percent of the FPL
♦ Provided a less inclusive health care benefit package than the current Medicaid program	♦ Offers the same health care benefits package as the current Medicaid program

- Outstationing of Eligibility Workers. With the separation of automatic Medicaid eligibility from cash assistance, and the implementation of W-2, the state will place eligibility workers in outstation sites. The expansion of sites available for applicants to apply for Medicaid will facilitate coverage of all eligible populations and also provide another avenue for BadgerCare applications.

- A unit of ten Milwaukee County eligibility workers will be outstationed at 22 new sites, including hospitals, clinics and community-based agencies that serve families who may be eligible for Medicaid. The Department is also soliciting interest from other counties to outstation eligibility workers and has

begun to work with interested groups in other areas of the state, including Dane and Kenosha Counties. The workers will have access to the Client Assistance for Reemployment and Economic Support (CARES) system to allow them to process applications and determine Medicaid eligibility.

- The outstationing of eligibility workers will be primarily focused on Milwaukee County, where nearly a quarter of all Wisconsin citizens with income less than 200 percent of the Federal Poverty Level reside. Milwaukee County also has 90 percent of the State's W-2 (TANF) caseload. Appendix A lists the sites which are being considered for outstationed eligibility workers. Children's Health System (affiliated with Children's Hospital of Wisconsin) is locating two of the twenty-two outstation sites in Milwaukee area schools. St. Mary's Hospital of Milwaukee is also interested in exploring the possibility of taking Medicaid applications at school sites.

- In Dane County, the second most populous county in the state, a proposal is under way to make eligibility workers available at outstation sites. These sites will include schools and other school districts as integral partners in the outreach and referral network. Kenosha, Monroe, and Oneida counties have also expressed an interest in outstationing eligibility workers at nontraditional sites.

- Compared to existing outstation sites at FQHCs and DSHs, which assist in the initial application processing for Medicaid, eligibility workers who are public employees are located at the new outstation sites to complete the entire Medicaid eligibility determination process. Along with this initiative, we also plan to work with counties to improve and expand on the traditional model of outstationing now used by FQHCs and DSHs.

- The Department will also be coordinating its outstationing efforts with those of the Wisconsin Primary Health Care Association (WPHCA). WPHCA was recently awarded a one-year Pilot Demonstration Project on Medicaid jointly sponsored by the Health Care Resources Administration (HCRA) and Health Care Financing Administration (HCFA). This project will allow the state to improve the outstationing currently conducted by staff of the federally qualified health centers (FQHCs) and a few tribal health centers.

This new project will:

- Provide a liaison and single point of contact between the Medicaid program and the FQHC outstationing to coordinate trouble-shooting, problem solving, and data collection.

- Test and evaluate innovative methods of public-private partnership in Medicaid enrollment.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-

private partnership:

Because BadgerCare has been fully implemented and has resulted in significantly reducing the number of uninsured children in Wisconsin our print material has modified with program information and transformed into fact sheet format on the Department's website. It is the Department's standard procedure to replace brochures with fact sheets once programs are fully implemented. Other forms of initial BadgerCare marketing and media coverage (with the exception of occasional Public Service Announcements) were also curtailed.

DHFS continues to partner with the Robert Wood Johnson grantee in Wisconsin as part of the Covering Kids and Families initiative to reach low income, uninsured children. Our continued caseload growth and Wisconsin's low rate of uninsured are indicators that this has been an effective strategy. In addition, DHFS is implementing outreach strategies to increase Food Stamp participation, which will also bring low-income families into the BadgerCare application process.

Initial data indicate that local outreach efforts that are part of a coordinated service delivery network including economic support agencies, health departments, community organizations and health care providers are more effective in reaching uninsured populations.

For example, a two-year project (through December 2002), funded by DHFS, Dane County, and local health care providers, focused primarily on outreach for the growing Hispanic population in Dane County. The project also provided enrollment assistance to other underinsured minority groups and assisted with the piloting of simplified application procedures with these populations.

Data available specifically from Dane County through the end of November 2002 indicate that the targeted effort was successful. A total of 694 applications (33% of total 2,122) were submitted for Hispanic households. Census information shows that Hispanics make up 3.4 percent of the target area population. In addition, other ethnic groups were served in a higher percentage relative to the target census data.

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. *(Previously 4.4.5.)* (Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E))(42CFR 457.80(c))

Family members are only eligible for BadgerCare if they meet all of the following conditions:

- They are not enrolled in any health insurance plan as defined in HIPAA.

- They have not been enrolled in a health plan meeting HIPAA criteria during the past three months.

- They do not currently have access to an employer-subsidized plan in which the employer pays 80 percent or more of the premium cost for family coverage.

If a person or family who is eligible for BadgerCare is required to pay a premium, but does not do so, that person or family cannot enroll in BadgerCare for six months after termination of eligibility (restrictive enrollment period) and must pay back any premiums owed from previous BadgerCare eligibility periods.

At the time of application, family members who state they meet the insurance-related criteria listed above can be made eligible for BadgerCare benefits on a fee-for-service basis, pending verification of their insurance status.

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

☒ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102)(a)(4) (42CFR 457.490(a))

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. (Section 2102)(a)(4)(42CFR 457.490(b))

Section 4. Eligibility Standards and Methodology (Section 2102(b))

☒ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))

4.1.1. ☐ Geographic area served by the Plan:
4.1.2. ☐ Age:
4.1.3. ☐ Income:
4.1.4. ☐ Resources (including any standards relating to spend downs and disposition of resources):
4.1.5. ☐ Residency (so long as residency requirement is not based on length of time in state):
4.1.6. ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility):
4.1.7. ☐ Access to or coverage under other health coverage:
4.1.8. ☐ Duration of eligibility:
4.1.9. ☐ Other standards (identify and describe):

An application for coverage under BadgerCare will be denied if such coverage exists.

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B)) (42CFR 457.320(b))

4.2.1. ☐ These standards do not discriminate on the basis of diagnosis.
4.2.2. ☐ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
4.2.3. ☐ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. (Section 2102)(b)(2)) (42CFR 457.350)

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). (Section 2106(b)(7)) (42CFR 457.305(b))

☐ Check here if this section does not apply to your state.

Under the original terms of our waiver Wisconsin was allowed to determine the

enrollment threshold. Wisconsin could restrict new applications deemed to exceed budgeted enrollment, although applications would be kept on a waiting list in the event additional State funds were appropriated. Those already enrolled in BadgerCare would remain eligible if they continued to meet program qualification.

Under amended terms of our federal waiver Wisconsin retained the right to cap enrollment, however, enactment of enrollment restrictions now results in the loss of our Title XXI enhanced matching funds for parents enrolled in BadgerCare. This waiver amendment condition effectively limits our ability to enact enrollment caps.

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including a state health benefits plan) are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A)) (42CFR 457.350(a)(1) and 457.80(c)(3))

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. (Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))

4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. (Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))

4.4.4.1. ☐ Coverage provided to children in families at or below 200 percent FPL: describe the methods of monitoring substitution.

4.4.4.2. ☐ Coverage provided to children in families over 200 percent and up to 250 percent FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

4.4.4.3. ☐ Coverage provided to children in families above 250 percent FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

4.4.4.4. ☐ If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The cost-effectiveness determination.

4.4.5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. (Section 2102)(b)(3)(D)) (42 CFR 457.125(a))

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: (Section 2102(c)(1)) (42CFR 457.90)

Also, see response in section 2.2.1

The primary focus of Phase 1 was children age 15 to 18. In conjunction with the Phase 1 Title XIX expansion for children ages 15 to 18 at 100 percent or less of the FPL, the Department submitted a Section 1115(a) Demonstration Waiver Request dated January 21, 1998. This proposal included an expansion of Wisconsin's Title XIX Medicaid program to extend Medicaid coverage to mothers whose children are temporarily absent from the home.

The further expansion of the BadgerCare program in Phase 2 took advantage of the outreach efforts that are already under way. The Department of Health and Family Services developed a comprehensive plan for outreach. The Department undertook a major outreach effort to inform eligible families of the availability of Medicaid and to assist them in enrolling in the program. These efforts transcended Phase 1 implementation of BadgerCare. The Department's outreach plan was to enroll reach out to families potentially eligible for Medicaid under the old AFDC standards and establish the foundation for education and enrollment of families into Phase 2 of BadgerCare. These efforts were highlighted by the following initiatives, described in detail in this section:

- Creation of a new Eligibility Bureau in the Division of Health Care Financing.
- Negotiation of a MOU with the Department of Workforce Development.
- Development of an outreach plan to increase Medicaid enrollment and to implement strategies to promote public health.

Eligibility Section. The Governor's Budget for the 1997-99 biennium, enacted on October 11, 1997, created a new Medicaid Eligibility Section in the Department of Health and Family Services. This Section is now in existence, and its staff and responsibilities were expanded to implement the start-up of the BadgerCare program.

MOU with Department of Workforce Development. A Memorandum of Understanding (MOU) with the Department of Workforce Development (DWD) lays out roles and responsibilities for the two state agencies. DWD is the agency responsible for the Wisconsin Works (W-2) program, which is designed to move people off the welfare rolls and into employment. The BadgerCare program is part of the Department's efforts to ensure that, as individuals make this transition, they continue to receive adequate health care coverage.

Strategies to Promote Public Health. The Department developed strategies to promote the health of the population through a variety of initiatives. These include the following:

- Assuring that eligible families are enrolled in Medicaid.
- Extending health care coverage to working families with BadgerCare.
- Establishing a medical home and access to quality preventive services through statewide expansion of managed care.
- Supporting "Healthy Community" initiatives.

Population health goals for Wisconsin are set in the Public Health Agenda for the Year 2000.

Outreach Plan. The Outreach Plan has five major components:

- Statewide public information campaign.
- Expanded training.
- Improved case-specific problem resolution.
- Systems changes.
- Support for regional and local initiatives, including the outstationing of eligibility workers.

The outreach program for BadgerCare complemented and built upon current Medicaid outreach initiatives.

A plan was developed during the first year of BadgerCare's implementation with the following goals:

- Support and enhance the implementation of W-2 (the state's TANF program, which replaces AFDC).
- Assure the participation of eligible families in Medicaid and BadgerCare.
- Invest in proven activities that will support access to health care for families.
- Improve the health status of the Wisconsin population.

Through our outreach plan, we hope to ensure that all uninsured families in Wisconsin are aware of the health care coverage that is available to them. As a result, we expect to enroll eligible families into Medicaid and BadgerCare.

Public Information Campaign. A comprehensive and coordinated effort was implemented to assure that accurate information is available to recipients and agencies that work with them about the impact of welfare reform on Medicaid eligibility. This public information campaign will provide the platform for BadgerCare. It was coordinated with the extensive marketing effort underway with the implementation of W-2 to connect with the business community and employers around the state.

A recipient brochure describing the differences between W-2 and Medicaid was distributed (300,000 printed), accompanied by an order form and poster, and was also be used for complementary materials such as bus posters and radio ads. This campaign was updated to incorporate BadgerCare in the spring of 1998.

A direct mailing to former Medicaid recipients was conducted during for the spring of 1998 to assure that all have accurate information about the changes that are occurring in the welfare system and how to take advantage of health care coverage available through Medicaid.

Fact sheets describing various Medicaid program components were developed as the base for various informational materials and for training. This approach was used to support BadgerCare implementation. Fact sheets are under development on a range of topics, such as Newborn Eligibility, SSI Medicaid, Immigrants, Presumptive Eligibility, Backdating Eligibility, and What Happens When I Get a Job. These will be published on the Wisconsin Medicaid Web site, and used as the basis for provider bulletins and computer-based, mini-training courses on various topics of interest to agencies, employers and health care providers that work with families who may be eligible for these programs.

DHFS materials for beneficiaries are tested with focus groups. The Department translates these materials, as appropriate, into Spanish and Hmong, and distributes these materials based upon the demographics of particular communities, to reach out to individuals for whom English is not their primary language. Existing advocacy networks and mailing lists are continually updated to assure timely and accurate information about the impact of welfare reform.

Training. New training materials and presentations on Medicaid eligibility have been developed, and will be modified to incorporate BadgerCare training for Medicaid expansions to new groups. Training for health care providers will be offered by the state's Medicaid fiscal agent, EDS. Training packages that can be used by other groups to reach their members will be available, for example, for staff of medical clinics and school nurses.

Training for advocacy groups and community-based agencies were developed and offered by Automated Health Systems, Inc., the Wisconsin Medicaid program's enrollment contractor, using regional managed care forums as well as other venues. Training for workers in W-2 and county agencies were coordinated with and offered through the Department of Workforce Development.

Case-Specific Problem Resolution. Wisconsin has included a problem resolution component in our outreach plan to provide one-on-one assistance to current and former recipients having problems accessing and navigating the changes in W-2 and Medicaid. Services offered at a toll-free number operated by the state are being expanded to include the capacity to research cases on both CARES and the MMIS, and to follow up with county agency staff to resolve case problems.

In addition to improved services to recipients and advocates, a redesign of state level help desk functions for county and W-2 staff has been completed. A new Call Center is in operation at the Department of Workforce Development, with expert back-up on Medicaid issues provided by staff of the Medicaid program. This service will be coordinated with the 800 number currently available to recipients and advocates.

Community-Based Initiatives to Complement the Statewide Activities. Support for regional and local outreach initiatives that complement the statewide outreach plan will also be provided, working with the county, tribal, and public health network throughout the state.

- Information products, training, improved systems for problem resolution, technical assistance and grants to support Medicaid outreach was made available to local agencies, including public health, tribal and community-based agencies. Local public health agencies supported and coordinated outreach activities with schools.

- The goal for the grants to local agencies is to support a range of complementary activities designed to inform the community, and to find and enroll eligible families in Medicaid and BadgerCare.

- Coordination between public health, community-based and tribal agencies, schools, and economic support agencies locally and at the state agency level is essential to success.

The plan will include specific strategies to assure access to the Medicaid program, and ultimately to BadgerCare, for priority populations, including tribal agencies. The timetable for grants will be as follows:

- Requests for proposals will be released during the summer of 1998.
- Funding will be made available through September 1999.
- A streamlined process will be employed to review grant proposals.
- Awards will range from $10,000 to $50,000.
- Regional coordination and replication of successful models will be encouraged.

Through these criteria, the Department will provide financial support for community-based initiatives that complement the statewide initiatives.

Outstationing of Eligibility Workers. With the separation of automatic Medicaid eligibility from cash assistance, and the implementation of W-2, the expansion of sites to apply for Medicaid will help to facilitate coverage of all eligible populations and will provide another avenue for BadgerCare applications.

A unit of ten Milwaukee County eligibility workers will be outstationed at new sites at health facilities and other community locations that serve families who may be eligible for Medicaid. The workers will have access to the CARES system to process applications and determine Medicaid eligibility. The state is also working with groups in several other areas of the state who are exploring outstationing options.

Systems Changes. The way in which the computer system interfaces with the user of the system can be a barrier to understanding eligibility in relation to a case-specific situation. For this reason, efforts are underway to address some of these concerns as part of the state's outreach plan.

Major changes have been made to the CARES system to implement W-2 and to separate Medicaid eligibility determination logic from the old AFDC program logic in CARES. Modifications were also made to the CARES screens that are used to identify the programs being requested, so that it is now assumed that an applicant wants to apply for Medicaid along with the application for other programs supported by CARES (i.e., W-2, Food Stamps, and Child Care).

Improvements to recipient notices generated by CARES will be included on the CARES schedule for work in 1998 as one component of the state's outreach strategy. Options for expanding the hours of availability of the CARES system for county agency workers are being developed to provide more flexibility to accommodate the needs of working families.

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

☒ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 7.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) (42CFR 457.410(a))

6.1.1. ☐ Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420))

6.1.1.1. ☐ FEHBP-equivalent coverage; (Section 2103(b)(1)) (If checked, attach copy of the plan.)

6.1.1.2. ☐ State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3. ☐ HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description).

6.1.2. ☐ Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430). Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431. See instructions.

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

6.1.4. ☐ Secretary-Approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)

6.1.4.1. ☐ Coverage the same as Medicaid State plan

6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration project

6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage

6.1.4.5. ☐ Coverage that is the same as defined by existing

comprehensive state-based coverage

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit-by-benefit comparison (Please provide a sample of how the comparison will be done)

6.1.4.7. ☐ Other (Describe)

6.2. The state elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42CFR 457.490)

6.2.1. ☐ Inpatient services (Section 2110(a)(1))

6.2.2. ☐ Outpatient services (Section 2110(a)(2))

6.2.3. ☐ Physician services (Section 2110(a)(3))

6.2.4. ☐ Surgical services (Section 2110(a)(4))

6.2.5. ☐ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))

6.2.6. ☐ Prescription drugs (Section 2110(a)(6))

6.2.7. ☐ Over-the-counter medications (Section 2110(a)(7))

6.2.8. ☐ Laboratory and radiological services (Section 2110(a)(8))

6.2.9. ☐ Pre-natal care and pre-pregnancy family services and supplies (Section 2110(a)(9))

6.2.10. ☐ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))

6.2.11. ☐ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11)

6.2.12. ☐ Durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))

6.2.13. ☐ Disposable medical supplies (Section 2110(a)(13))

6.2.14. ☐ Home and community-based health care services (See instructions) (Section 2110(a)(14))

6.2.15. ☐ Nursing care services (See instructions) (Section 2110(a)(15))

6.2.16. ☐ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16))

6.2.17. ☐ Dental services (Section 2110(a)(17))

6.2.18. ☐ Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))

6.2.19. ☐ Outpatient substance abuse treatment services (Section 2110(a)(19))

6.2.20. ☐ Case management services (Section 2110(a)(20))

6.2.21. ☐ Care coordination services (Section 2110(a)(21))

6.2.22. ☐ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))

6.2.23. ☐ Hospice care (Section 2110(a)(23))

6.2.24. ☐ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))

6.2.25. ☐ Premiums for private health care insurance coverage (Section 2110(a)(25))

6.2.26. ☐ Medical transportation (Section 2110(a)(26))

6.2.27. ☐ Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))

6.2.28. ☐ Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42CFR 457.480)

6.3.1. ☐ The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR

6.3.2. ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Please describe: *Previously 8.6*

6.4 Additional Purchase Options. If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: (Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)

6.4.1. ☐ Cost Effective Coverage. Payment may be made to a state in excess of the 10 percent limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income

children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following (42CFR 457.1005(a)):

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above. Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))

6.4.2. ☐ Purchase of Family Coverage. Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3)) (42CFR 457.1010)

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and (Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children). (Section 2105(c)(3)(A)) (42CFR 457.1010(a))

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B)) (42CFR 457.1010(b))

6.4.2.2.1.1. The state assures that the coverage for the family otherwise meets title XXI requirements. (42CFR 457.1010(c))

Section 7. Quality and Appropriateness of Care

☒ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (2102(a)(7)(A)) (42CFR 457.495(a))

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☐ Quality standards

7.1.2. ☐ Performance measurement (MEDDIC-MS)

7.1.3. ☐ Information strategies

7.1.4. ☐ Quality improvement strategies

7.2. Describe the methods used, including monitoring, to assure: (2102(a)(7)(B)) (42CFR 457.495)

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))

7.2.2 Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42CFR 457.495(b))

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d))

Section 8. Cost Sharing and Payment (Section 2103(e))

☒ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 9.

8.1. Is cost sharing imposed on any of the children covered under the plan? (42CFR 457.505)

8.1.1. ☐ YES

8.1.2. ☐ NO, skip to question 8.8.

8.2. Describe the amount of cost sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.
(Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2.1. Premiums:

8.2.2. Deductibles:

8.2.3. Coinsurance or copayments:

8.2.4. Other:

8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)((1)(B)) (42CFR 457.505(b))

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

8.4.1. ☐ Cost sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42CFR 457.530)

8.4.2. ☐ No cost sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)

8.4.3 ☐ No additional cost sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515(f))

8.5. Describe how the state will ensure that the annual aggregate cost sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

8.6 Describe the procedures the state will use to ensure American Indian (as defined by the

Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)

8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

☐ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))

☐ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))

☐ In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))

☐ The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

8.8.1. ☐ No Federal funds will be used toward state matching requirements. (Section 2105(c)(4)) (42CFR 457.220)

8.8.2. ☐ No cost sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. (Section 2105(c)(5) (42CFR 457.224) (*Previously 8.4.5)*

8.8.3. ☐ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

8.8.4. ☐ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))

8.8.5. ☐ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)

8.8.6. ☐ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42CFR 457.710(b))

Wisconsin's BadgerCare program will attempt to address four fundamental goals:

1) Increased access to coverage
2) Increased access to services
3) Improved health outcomes and quality of care
4) Improved delivery systems impacts

In Phase 1, these goals will be applied to the more modest effort of providing health care coverage for children age 15 to 18 up to 100 percent of the Federal Poverty Level (FPL). In Phase 2, more ambitious goals for a larger eligibility group will be implemented.

BadgerCare Phase 1 Goals

Access to coverage. Previously uninsured children who may potentially be eligible for the BadgerCare program will be identified through ongoing outreach activities. Low-income children who were previously without health insurance coverage will have health insurance coverage through the BadgerCare program.

Access to services. Children enrolled in the BadgerCare program will have a consistent source of health care.

Health outcomes and quality of care. Wisconsin's BadgerCare program will improve the health status of children enrolled in the program as well as improve the overall health care system accessed through the program.

Delivery systems impacts. The infrastructure of the Department of Health and Family Services will be able to accommodate all critical facets of Phase 1 of Wisconsin's BadgerCare program. Phase 1 is defined as expanding Medicaid program eligibility under Title XIX of the Social Security Act (SSA) to uninsured children who are less than 19 years of age, born on or before September 30, 1983, and who have incomes equal to or less than 100 percent of the FPL.

BadgerCare Phase 2 Goals

Access to coverage. Some families who join the workforce have access to affordable, employer-provided health care. For many others, however, access and affordability is an issue. Through a comprehensive, integrated program, BadgerCare builds a bridge between Medicaid and employer-provided health care coverage, just as welfare reform is now transforming the ties between welfare and work.

To preserve access to health care for low-income families and children, Medicaid must change to recognize that a majority of low-income families now work, that AFDC income standards required for Medicaid are significantly less than the minimum wage, and that health care is not always accessible or affordable through employment. Through strengthening the ability of both parents to be employed and to care for their children, BadgerCare supports the transition to independence.

In addition, given the different and more generous standards for W-2 and the complexity and intricacies of former AFDC rules, many low-income families are no longer eligible for Medicaid based on prior AFDC standards or no longer understand that they may be eligible under obsolete, confusing AFDC standards.

Just as welfare reform is now experimenting with creative links between cash assistance and employment, BadgerCare is an innovative and progressive model to effectively integrate Medicaid with employment-based health insurance. BadgerCare builds upon the intent of Title XXI to accomplish this integration.

BadgerCare will provide access to health care, without supplanting private insurance by incorporating the following mechanisms:

- Applicants who are covered under a health insurance plan as defined in HIPAA will not be eligible for BadgerCare.

- Applicants who have access to coverage under family health insurance subsidized by an employer at 80 percent or more of the premium cost will not be eligible for BadgerCare.

- Applicants who were covered during the three months prior to application under employer family health insurance plans meeting HIPPA standards for family coverage will be ineligible for BadgerCare. However, exceptions will be made where prior coverage ended due to reasons unrelated to the availability of BadgerCare. These reasons include, but are not limited to:

  - Loss of employment due to factors other than voluntary termination;
  - Change to a new employer that does not offer family coverage;
  - Change of address so that the individual is now outside the employer-sponsored insurance plan's service territory;
  - Discontinuation of health benefits to all employees by the applicant's employer; and
  - Expiration of COBRA coverage period.

- The Department intends to purchase family coverage made available by the employer of members of an eligible family when the employer's contribution is greater than 40 percent but less than 80 percent. This will only occur when the Department determines that purchasing the employer coverage would be more cost-

effective than providing the coverage directly under BadgerCare. The cost effectiveness will compare the cost to the state to buy in to the employer's plan versus the cost to directly provide coverage to the recipient.

- The Wisconsin Medicaid fiscal agent will notify the applicant, employer, insurance company, if necessary and the involved certifying agency of the cost-effectiveness decision and terms of the agreement.
- The Wisconsin Medicaid fiscal agent will establish a communication protocol with each employer regarding notification of the applicant's employment, coverage levels and premium amounts.
- The Wisconsin Medicaid fiscal agent will monitor employers' health insurance plans for open enrollment periods and will conduct an employer telephone inquiry to obtain the necessary cost-effectiveness information to facilitate insurance buy-in when available.
- The Wisconsin Medicaid fiscal agent will gather information regarding the applicant's access to and/or participation in the employer's health insurance plan beyond the previous three-month period for informational purposes only. EDS and Department staff will monitor this information for crowd-out impact.
- The Wisconsin Medicaid fiscal agent will verify health insurance coverage through the existing insurance exchange process with insurance carriers and telephone inquiries. EDS currently electronically exchanges insurance information with 95 percent of the insurance carriers, by market share in the state.
- If the verification shows that BadgerCare family members are currently covered or were covered within the past three months by an insurance plan meeting HIPAA standards, or currently have access to such a plan, subsidized at 80 percent or more of the premium cost, eligibility for BadgerCare ends.

  If the verification shows that BadgerCare family members have access to (but not coverage) employer family health insurance coverage subsidized at less than 80 percent of the premium cost, they continue to receive BadgerCare benefits on a fee-for-service basis, pending qualification for the HIPP Program.
- Participating families with incomes at or above 150 percent of the FPL will be assessed a premium cost share of 5 percent of their monthly family income.
- The Department will limit eligibility to those families whose income does not exceed 185 percent of the FPL. Employer-subsidized health insurance is not common among families with income this low.
- A provision of 1995 Wisconsin Act 289 required Wisconsin employers offering employee health insurance to include all employees. This was designed to prevent employers from offering a health insurance plan to only higher-compensated employees.

- Wisconsin has legislation pending to create a small employer insurance pool.

While we believe the measures listed above will be sufficient to prevent crowd-out, implementation of BadgerCare will be carefully monitored to assess any adverse impact BadgerCare may create for both employee use of employer-subsidized coverage, and employer reductions in offering coverage to workers. Monitoring can be done using reports produced by the Department's Center for Health Statistics. If it appears additional measures are needed, the state will investigate the following mechanisms as additional tools to use in preventing insurance crowd-out.

- Establishing limited entry/enrollment periods for BadgerCare. This will encourage employees to purchase on-going medical care through employer-subsidized insurance, rather than depending on BadgerCare exclusively for episodes of ill-health.

- Enactment of insurance reforms to encourage coverage of all employees. The Department intends to continue working with employers and the state Office of the Commissioner of Insurance to encourage broad-based health coverage of all employees.

Access to services. Through BadgerCare, the Department will integrate employer health care and Medicaid without supplanting private insurance. This will help to assure access to health care for all low-income families who do not have employer insurance. Access is balanced with personal responsibility through cost-sharing.

Health outcomes and quality of care. The major goal of BadgerCare is to improve the health of Wisconsin's low-income families with children by providing access to affordable health care for low-income families with children. We expect to improve health outcomes and reduce unnecessary and uncompensated health care costs by establishing a medical "home" for all low-income families and children, thereby strengthening health care prevention in the community.

To measure these health outcomes, we will use the same HEDIS measures as we do for the current AFDC-related/Healthy Start HMO program.

Wisconsin's AFDC/HMO program currently provides financial incentives to participating HMOs that provide the targeted number of HealthCheck screens to enrolled eligible children. The AFDC/HMO contract and capitation rate provides additional funds to HMOs to meet targeted levels of screening equal to 80 percent of those eligible. Funds are recouped at the close of the contract year if the HMO does not meet the required target. The HMOs have the financial incentive to meet the screening targets and retain the HealthCheck funds. A HealthCheck screening requirement and financial incentive will be a requirement of HMOs serving the BadgerCare population.

In addition, the Department is in the planning stages of establishing a series of performance-based contract measures designed to enhance quality of care and administrative efficiencies. The system will initially be limited to four or five measures that are reasonably attainable and consistent with established guidelines and standards. A bonus payment system is being planned for the 1999 contract year for

the AFDC/Healthy Start HMO program and possibly for BadgerCare HMO programs. This bonus system will provide financial incentives to HMOs that meet performance targets.

We are currently considering linking HMO bonus payments to meeting new performance targets that address the health needs of women and children by assuring that HMOs provide PAP and STD screening and childhood immunizations at appropriate rates and intervals. If there is sufficient time to develop initiatives for BadgerCare in 1999, we will consider implementing performance standards in the year 2000.

Delivery systems impacts. As part of the BadgerCare program, Wisconsin will make an effort to further streamline eligibility procedures. The BadgerCare program will build upon the success of the state's program of Health Maintenance Organization (HMO) enrollment for health care. BadgerCare will provide Wisconsin Medicaid's comprehensive benefits and services through a health care delivery system with strong quality assurance safeguards.

Currently, 18 of 24 licensed HMOs in Wisconsin participate in the Wisconsin Medicaid HMO program. In 1998, Medicaid-certified HMOs will participate in 70 of the State's 72 counties (fee-for-service remains in the two remaining small, rural counties). With clear and measurable performance standards, and ongoing, continuous quality improvement activities, the Wisconsin Medicaid HMO program has demonstrated improved health outcomes. The Wisconsin Medicaid HMO contract for low-income families with children is frequently identified as one of the best in the nation.

BadgerCare will prevent crowd-out of private insurance by buying employees into employer-based group health coverage when it is available and it is cost-effective to do so. In these situations, BadgerCare will provide wraparound services to BadgerCare recipients in employer health insurance plans up to the Medicaid benefit level, including any deductibles, coinsurance, and copayments that may be imposed on the employee by the employer's health insurance plan.

9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c))

As described in response to question 9.1, BadgerCare will promote the achievement of the following four goals:

1) Increasing access to coverage
2) Increasing access to services
3) Improved health outcomes and quality of care
4) Improved delivery systems impacts

Access to health care coverage. BadgerCare will increase the number of insured Wisconsin residents, primarily children. BadgerCare will increase the number of children insured by enrolling entire families. BadgerCare will improve the outreach to

and increases the enrollment of Medicaid-eligible children and adults.

BadgerCare will not cause "crowding out." That is, persons who enroll in BadgerCare will not drop other insurance coverage in order to participate in BadgerCare. Employers will not change the coverage they offer in response to the availability of BadgerCare.

We do not believe "adverse selection" will be an issue in the implementation of BadgerCare. Disabled children will continue to be eligible for Medicaid through the state's categorical and medically needy provisions for SSI-related recipients. We believe enrollees in BadgerCare will report that they are satisfied with the price they have to pay for coverage and the choice of coverage available to them.

Access to services. Wisconsin predicts that BadgerCare will produce positive results relating to access to services. A greater share of BadgerCare enrollees will have a primary care physician than the general public. Utilization of services patterns for BadgerCare enrollees will be enhanced by linking recipients to a "medical home." BadgerCare and Medicaid enrollees will report satisfaction with the simplified eligibility process. BadgerCare enrollees will report that they are satisfied with their access to services as measured by criteria such as waiting times for appointments. Enrollees in BadgerCare will be satisfied with their ability to get referrals to specialists. Pregnant women enrolled in BadgerCare will have greater access to prenatal care services than a comparison population.

Health outcomes and quality of care. Wisconsin predicts that BadgerCare will produce positive results relating to health outcomes and quality of care. BadgerCare enrollees will self-report improved health status. BadgerCare enrollees will utilize more preventive and primary care services than a comparison population. BadgerCare enrollees will have greater continuity of care than a comparison population. BadgerCare enrollees will have fewer preventable hospitalizations than a comparison population. Enrollees in BadgerCare will report they are satisfied with the quality of care they receive.

Delivery system impacts. Wisconsin predicts that BadgerCare will produce positive results relating to delivery system impacts. BadgerCare will not result in employers reducing their health insurance benefit packages. Persons enrolling in BadgerCare will not drop existing coverage to enroll in BadgerCare. Enrollment in BadgerCare will increase the likelihood of obtaining employment. Enrollment in BadgerCare will reduce the likelihood that an enrollee will utilize welfare services. BadgerCare will result in greater HMO capacity in Wisconsin. BadgerCare will result in long-term savings for the Medicaid program.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:
(Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

A table entitled "Timeframes and Specific Objectives/Goals for Phase 1 of BadgerCare"

is included as Appendix B of this document. A summary of how performance under the plan will be measured follows.

Data Sources/Analysis Plan

The analysis plan uses a variety of approaches and multiple data sources. Some aspects of the analysis are much more difficult to quantify than others. While there is considerable existing data available, some analyses will require primary data collection through direct contact via a survey or other means. Some parts of the evaluation will require the development of a control or comparison group to determine program impact.

Baseline data

The state will measure these types of outcomes and behavior from standard enrollment data available from the CARES system and utilization data reported by BadgerCare HMOs. BadgerCare HMOs will provide the state summary utilization survey data on key indicators (PAP tests, mammographies, immunizations, HealthChecks, mental health and substance abuse evaluations, emergency room visits, etc.) as well as complete utilization history for all BadgerCare recipients. In addition, beginning in the year 2000, BadgerCare HMOs will be required to submit complete encounter data for all their recipients. Access and utilization data for the general population is available in reports and data bases produced and maintained by the Department's Office of Health Care Information, the Department's Center for Health Statistics, and the Wisconsin Office of the Commissioner of Insurance.

With this comprehensive utilization data available, the State will be able to analyze BadgerCare access and utilization data and compare it to traditional Medicaid populations and general populations. Wisconsin has been in the forefront of states in its ability to report health care utilization and status across Medicaid, commercial, and other public program populations, and to measure utilization rates and health status indicators against defined public goals such as the Wisconsin Public Health Agenda 2000.

The reporting and evaluation of BadgerCare will continue that tradition.

Subsequent data collection

The primary sources of data envisioned for this evaluation are as follows:

- Surveys. An enrollee satisfaction survey will be administered to obtain data to test a number of hypotheses. The survey will provide information on enrollees' satisfaction with their choice of plan, the care they receive, the premium amounts, the accessibility of care and the quality of care. The survey will also be a basis for self-reported health status and health risk behavior data as well as utilization data. A stratified random sample of enrollees will be selected to ensure geographic and demographic representation. Consideration will be given to whether it will be necessary to conduct this survey at least twice, once as a baseline and at least once as follow-up.

- Interviews. To obtain information on employers' response to BadgerCare it will be necessary to contact employers through either a survey or an interview method or both. The favored approach will be to survey a sample of employers and, based on the survey results, select a small number for in-depth interviews.

- HMO Histories. Enrollee and service specific data will be generated for all BadgerCare enrollees. These data will form the basis for special studies and auditing individual recipients. Quality of care and access issues will be addressed using these data as a sampling frame. The data received through the ongoing Medicaid Managed Care Quality Improvement Program will serve as the source for such data.

- Special reports. Special ad hoc reports will be designed based on claims or aggregate HMO reporting. These reports can be used to monitor BadgerCare performance on various utilization and health status measures. Sentinel indicators will be identified and included in these reports.

- Some special reports may be developed to monitor service utilization and outcomes for BadgerCare enrollees who have been bought into health insurance plans offered through their employers. In these cases, detailed utilization data may not be available in a feasible and cost-effective manner, so proxy measures may have to be developed.

- Medical Records Audits. The current auditing of the Medicaid managed care program, performed by Department staff and contractors, will be expanded to encompass the BadgerCare program.

Control Group

A number of hypotheses suggest an evaluation design that requires a control group or a pre-post design. A suitable control group for many of the hypotheses will be Medicaid recipients either selected randomly or matched by characteristics to better mirror the BadgerCare enrollees. On other occasions a pre-post analysis will dictate that baseline information be collected and then replicated at a later date.

Other control groups may be some subset of the general insured population that may have health insurance with a less generous benefit package than BadgerCare.

Check the applicable suggested performance measurements listed below that the state plans to use: (Section 2107(a)(4))

9.3.1. ☐ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.

9.3.2. ☐ The reduction in the percentage of uninsured children.

9.3.3. ☐ The increase in the percentage of children with a usual source of care.

9.3.4. ☐ The extent to which outcome measures show progress on one or more of the health problems identified by the state.

9.3.5. ☐ HEDIS Measurement Set relevant to children and adolescents younger than 19.

9.3.6. ☒ Other child appropriate measurement set. List or describe the set used.

Please see attached "Addendum IV - Contract-Specified Reporting Requirements," from the January 1998 - December 1999 Contract for Medicaid services Between HMO and Wisconsin Department of Family Services."

The *Wisconsin Medicaid Health Maintenance Organization (HMO) Reporting Documentation User Manual*, January 1998, provides a correlation between the reports listed in Addendum IV and the strategic objectives and performance goals which we indicate that they address. A copy of the *User Manual* was included with our responses to HCFA's questions about Wisconsin's Phase 1 application.

Data from the utilization survey requirement described in Addendum IV will provide indications of health care utilization in key preventive health areas within the HMOs. Important indicators we will use include the following: rates of HealthCheck (EPSDT) services, rates of PAP testing, rates of ambulatory follow-up for recipients discharged from a hospital with mental health or AODA diagnoses, rates of hospitalization for recipients with asthma, rates of primary care provider visits, and rates of dental preventive care.

9.3.7. ☐ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

- 9.3.7.1. ☒ Immunizations
- 9.3.7.2. ☒ Well-child care
- 9.3.7.3. ☒ Adolescent well visits
- 9.3.7.4. ☒ Satisfaction with care
- 9.3.7.5. ☒ Mental health
- 9.3.7.6. ☒ Dental care
- 9.3.7.7. ☒ Other, please list:

9.3.8. ☐ Performance measures for special targeted populations.

9.4. ☒ The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42CFR 457.720)

9.5. ☒ The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2)) (42CFR 457.750)

The data sources and analysis plan described in the response to Question 9.3 will provide the information necessary to prepare these reports.

In addition, to obtain information about children without creditable coverage, we will rely on the *Wisconsin Family Health Survey*, which was discussed extensively in Section 2.1. As indicated in section 2.1, the survey was started in 1989 to collect information on the health status, health problems, health insurance coverage, and use of health care services among Wisconsin residents. The survey will create the baseline data on children without creditable coverage sufficient to provide the information requested in the table to Section 10.1.

United States Census data will also be used to create the baseline information needed to evaluate the success of BadgerCare.

Further, the Department is creating a data warehouse. This warehouse will compile data from the CARES system and from Medicaid. This warehouse should be up and running by the year 2000.

9.6. ☒ The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3)) (42CFR 457.720)

9.7. ☒ The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.135)

9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)

9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)

9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)

9.8.4. ☒ Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the

design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))

When the BadgerCare program was in the start-up phase, steps were taken to bring the new program to the attention of the public. Now that it is an established program, ongoing efforts to inform Wisconsin residents of the availability of assistance with their health care needs include information about BadgerCare.

Information for providers. The Wisconsin Department of Health and Family Services regularly publishes the Medicaid and BadgerCare update. This document describes itself as the first source of program policy and billing information for providers. It includes language that specifically states that "Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also."

Information for recipients. Information for Medicaid recipients is provided to those seeking assistance through paper copy of information brochures as well as documents which are available through the Department web site.

- On the Medicaid web site, there is a heading that reads "Related Programs and Services." The first link under this heading is for the "BadgerCare Web site."

- The application for Medicaid is combined with that for BadgerCare, and bears the title "Medicaid, BadgerCare, and Family Planning Waiver Registration Application."

- "A Guide to the Wisconsin Medicaid and BadgerCare HMO Program." This document describes the role that managed care plays in delivering health care services to recipients under BadgerCare or Medicaid.

- "Wisconsin Medicaid and BadgerCare Fact Sheet." This document goes on to provide the following information: "Applying for Medicaid in Wisconsin. When you apply for WI Medicaid or BadgerCare you will need to provide certain information. ..."

In short, wherever information appears about Wisconsin Medicaid, information is also provided about the BadgerCare program. The two sets of information appear in tandem.

Changes in rates and benefits. The benefit package available under BadgerCare is identical to that offered to Medicaid recipients. However, there was recently a change in co-payments required of recipients for prescription drugs, as well as a change in premiums required of BadgerCare recipients above a certain income level. The public was notified of these changes through a notice in the Wisconsin Administrative Register on June 30, 2003. The Wisconsin Administrative Register is the equivalent of the Federal Register. Federal regulations require that changes in rates and benefits for Medicaid recipients be published in a periodical which is the equivalent of the Federal Register. The Wisconsin Administrative Register serves this role in the State of Wisconsin.

As previously stated, Wisconsin's efforts to provide information about the Wisconsin Medicaid program includes information about the BadgerCare program. The Department of Health and Family Services recognizes that some people who are not eligible for Medicaid will meet the eligibility criteria for BadgerCare.

9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR 457.125. (Section 2107(c)) (42CFR 457.120(c))

The Department has had long experience in working closely with Native Americans in developing and implementing State health programs.

We continue to hold meetings with tribal leaders to discuss health care related issues. We continue to use these meetings to solicit input and provide information to the tribes on BadgerCare.

Department staff also attend meetings with the Great Lakes Inter-Tribal Council, Inc. (GLITC Inc.) and individual tribal health clinics to discuss various aspects of BadgerCare and how they may impact on the Indian Health Service.

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in §457.65(b) through (d).

Not applicable.

9.10. Provide a one-year projected budget. A suggested financial form for the budget is attached. The budget must describe: (Section 2107(d)) (42CFR 457.140)

- Planned use of funds, including:
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.

Projected sources of non-Federal plan expenditures, including any requirements for cost sharing by enrollees.

COST PROJECTIONS OF DEMONSTRATION (SECTION 1115 or HIFA)	Reporting Period (FFY 03)	Next Fiscal Year (FFY 04)	Following Fiscal Year (FFY 05)
Benefit Costs for Demonstration Population #1 (e.g., children)			
Insurance Payments	40,026	40,427	41,200
Managed care	22,607,882	27,837,946	29,925,800
Per member/per month rate @ # of eligibles	80.07	84.19	91.43
Fee for Service	10,665,532	15,026,607	16,153,200
Total Benefit Costs for Waiver Population #1	***33,313,440***	***42,904,980***	***46,120,200***
Benefit Costs for Demonstration Population #2 (e.g., parents)			
Insurance Payments	57,405	57,979	59,100
Managed care	68,789,421	79,707,699	93,053,100
Per member/per month rate @ # of eligibles	189.47	199.23	216.36
Fee for Service	25,141,659	29,868,759	32,108,900
Total Benefit Costs for Waiver Population #2	***93,988,485***	***109,634,437***	***125,221,100***
Benefit Costs for Demonstration Population #3 (e.g., pregnant women)			
Insurance Payments			
Managed care			
Per member/per month rate @ # of eligibles			
Fee for Service			
Total Benefit Costs for Waiver Population #3			
Total Benefit Costs	**127,301,925**	**152,539,417**	**171,341,300**
(Offsetting Beneficiary Cost Sharing Payments)	-5,010,942	-5,261,490	-5,419,400
Net Benefit Costs (Total Benefit Costs - Offsetting Beneficiary Cost Sharing Payments)	**122,290,983**	**147,277,927**	**165,921,900**
Administration Costs			
Personnel	130,916	137,462	144,400
General Administration	11,212,622	6,269,888	6,583,400
Contractors/Brokers *(e.g., enrollment contractors)*			
Claims Processing			
Outreach/Marketing costs			
Other *(specify)*			
Total Administration Costs	**11,343,538**	**6,407,350**	**6,727,800**
10 percent Administrative Cap (net benefit costs ÷ 9)	**14,457,675**	**16,364,214**	**18,435,770**
Federal Title XXI Share	**94,908,765**	**109,116,547**	**122,581,287**
State Share	**38,725,756**	**44,568,730**	**50,068,413**
TOTAL COSTS OF DEMONSTRATION	**133,634,521**	**153,685,277**	**172,649,700**

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42CFR 457.750)

10.1.1. ☒ The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. ☒ The state assures it will comply with future reporting requirements as they are developed. **(42CFR 457.710(e))**

10.3. ☒ The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

Section 11. **Program Integrity (Section 2101(a))**

☒ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue to Section 12.

11.1 ☐ The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.935(b)). *The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)*

11.2.1. ☐ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)

11.2.2. ☐ Section 1124 (relating to disclosure of ownership and related information)

11.2.3. ☐ Section 1126 (relating to disclosure of information about certain convicted individuals)

11.2.4. ☐ Section 1128A (relating to civil monetary penalties)

11.2.5. ☐ Section 1128B (relating to criminal penalties for certain additional charges)

11.2.6. ☐ Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and enrollee protections (Sections 2101(a))

☒ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan.

Eligibility and Enrollment Matters

12.1 Please describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120.

Health Services Matters

12.2 Please describe the review process for health services matters that comply with 42 CFR 457.1120.

Premium Assistance Programs

12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.